reviews

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Scanty Particulars: The Strange Life and Astonishing Secret of Victorian Adventurer and Pioneer Surgeon James Barry

Rachel Holmes

Viking, £14.99, pp 352
ISBN 0 670 89099 5

Rating: ★★

James Barry started his medical training in Edinburgh and undertook further study in London under Astley Cooper. He then joined the army as a surgeon and rose to be the most senior member of Her Majesty's Inspectors General of Hospitals.

He spent almost all his working life abroad, where he "established a reputation as a vain, quarrelsome troublemaker." He was also known as a highly skilled doctor, being one of the few of his time to perform a caesarean in which both mother and child survived. As a humanitarian reformer he fought for the humane treatment of "women, children, slaves, prostitutes, prisoners, the insane, and the poverty stricken," and he was also a great conversationalist.

The real fascination of Barry, however, was his appearance. Less than five feet tall, he had delicate features, dressed in the most extravagant uniform, and dyed his hair red. Wherever he went he was accompanied by a black servant nicknamed "Black John" and a series of pet dogs, all called "Psyche." Barry would never allow anyone to see him undress and insisted that when he died "he should be buried in his bed sheets without further inspection."

When he died in 1865, at the age of about 70, there was no postmortem examination. Sophia Bishop, the woman employed to lay him out, was shocked to discover that James Barry was female and also had striae on her abdomen. The evidence of Sophia Bishop is not disputed. The author, however, discusses it in a rather muddled way by suggesting that Barry was possibly some kind of hermaphrodite. The most likely interpretation, although far from certain, is that Barry was a physically normal girl who decided to dress and behave as a man in order to study medicine. His mother had a daughter who died at the same time as the appearance of a "nephew," James Barry. Through comparing the handwriting of the supposed dead daughter and that of James Barry it appears they were the same person. Thus James Barry was able to hide all information about his childhood, including his date of birth, and probably, but this is only my guess, with the mother's collusion.

The book is written for a non-academic readership. The language is often sensationalist and journalese, such as describing a person's name as "his moniker." Because this is a story of a highly successful deception, it is packed with uncertainties and ambiguities. But some of the uncertainties are the result of clumsy writing. The author's excursions into medical history are often wide of the mark, and her knowledge of anatomy and sexual abnormalities appears to be slight. Although the author claims an academic background, there are no references and only a very short bibliography. This means that the critical reader has no idea of the origin or reliability of the numerous quotations and assertions. Non-critical readers, however, can be assured that they will be entertained by this extraordinary biography.

Irvine Loudon *medical historian, Wantage*

Science Fictions: A Scientific Mystery, a Massive Cover-up, and the Dark Legacy of Robert Gallo

John Crewdson

Little, Brown and Company, $27.95/£19.67, pp 670
ISBN 0 316 13476 7

Rating: 0

It's fairly clear that Robert Gallo is not a very likeable man. In the race to identify the cause of AIDS, he threatened his rivals, bullied his collaborators, and lied to editors of journals. Although never proved, it seems more than possible that HTLV-III, the retrovirus that he claimed to have discovered, had been deliberately misappropriated from cell lines sent to him from the Pasteur Institute in Paris and given a new name.

Crewdson, an investigative journalist on the *Chicago Tribune*, is apparently appalled that a scientist could behave in this way. In 1989, he wrote a long article for his newspaper about the Gallo-Montagnier controversy in which he accused Gallo of malpractice. Here, after exhaustive scrutiny of correspondence, memoranda, laboratory notebooks, and the transcripts of the official investigations, he takes nearly 700 pages to tell an updated version of the same story.

Crewdson believes that Gallo abandoned all moral and scientific principles in the singleminded pursuit of a Nobel prize. To persuade us that this judgment is correct, he overwhelms us with evidence, often quoting verbatim from the protagonists' own accounts. This makes the book tough going because it is hard not to lose the scientific plot in the minutiae of who said what to whom. And despite the weight of information Crewdson amasses, it's ultimately unconvincing. One has no way of knowing whether it has been presented in a fair minded way. There's a strong sense of only hearing the case for the prosecution. Don't read the book hoping for a history of AIDS research, an account of the biology of retroviruses, or a psychological profile of the main characters. You'll be disappointed.

The author's shock at discovering that scientists are not always honourable in their dealings must surely be simulated. It's a commonplace observation that important discoveries are made by unpleasant people. (Forgive me if I don't give medical examples here.) And the phrase in the subtitle, the dark legacy of Robert Gallo, which implies that lasting harm was done and which, I guess, Crewdson must need to believe to justify writing the book, is never supported by argument or facts. It's far from clear that progress in understanding the causation of AIDS was slowed up by anything Gallo did. Indeed, the reverse might well be true.

Christopher Martyn *BMJ*

Items reviewed are rated on a 4 star scale (4=excellent)

Celebrity selling

By spreading the word about osteoporosis, Camilla Parker Bowles, companion to Prince Charles, is inadvertently raising awareness about the latest trend in global drug promotion

Working round the clock from her home office in New Jersey, Amy Doner Schachtel is at the cutting edge of medical research—she helps drug companies find celebrities to help expand markets for new medicines.

Chatting on the phone one night last week, Ms Doner Schachtel explained how she worked with big pharmaceutical companies to locate high profile personalities to talk about low profile diseases. The research she does for the companies and their public relations firms was not promoting drugs, she stressed, but raising awareness. "The trend is growing dramatically," she said.

Thanks to this experienced public relations agent and her company, Premier Entertainment, the American public learnt about irritable bowel syndrome from the star of the sitcom *Frasier*, Kelsey Grammer, and his wife, who has the condition. They appeared publicly on behalf of a foundation for gut disorders. The celebrity awareness-raising campaign was funded by GlaxoSmithKline, makers of the irritable bowel syndrome drug Lotronex (alosetron hydrochloride). Around the same time, that drug was withdrawn from the market after reports of serious side effects, including deaths.

In 1999 Ms Doner Schachtel lined up film and television star Cybill Shepherd to talk about the menopause and a big-selling supplement for symptom relief. As luck would have it, Cybill was taking the supplement with "tremendous results," said Ms Doner Schachtel. That gig was funded directly by the manufacturer, an Australian company called Novogen.

Both of the celebrity campaigns were a huge success in the enormous US healthcare market. The *Frasier* pair made the *Today Show* and Cybill made *Oprah Winfrey*.

While Camilla Parker Bowles's recent appearances talking about osteoporosis have been somewhat more modest, her comments on the bone condition have nevertheless attracted media attention. Unlike the television stars she is not being paid by a drug or supplement company, but rather is advocating on behalf of a charity she helps to run: the National Osteoporosis Society.

THE KOBAL COLLECTION

Cybill Shepherd: "tremendous results"

However, her awareness-raising activities do appear somehow to be synchronised with a much larger global campaign being underwritten by the world's biggest pharmaceutical companies.

Motivated by her own family's health problems, Mrs Parker Bowles became a patron of Britain's Bath-based National Osteoporosis Society in 1997, and president in 2001. But it was not until last month that she made her first major speech on the subject.

The location was Lisbon. The setting was the Roundtable of International Women Leaders. The commercial sponsor for the meeting was Lilly, the manufacturer of a new osteoporosis drug called Evista (raloxifene).

On 11 May, at the Lisbon meeting, Mrs Parker Bowles described how her mother and grandmother "both tragically died as a result of this crippling disease." She explained that, as a result of her mother's death, "I became determined to find some way of helping people with osteoporosis from experiencing the same fate and general disregard that she encountered."

Her message for health authorities was clear: "There are not enough DXA scanners, not enough staff to monitor them; not enough physios or special nurses, or money to help fund the vital research… We must emphasise the importance of spending more money on early diagnosis."

Importantly, Mrs Parker Bowles also signed a "call to action" urging governments across the globe to "make the diagnosis and treatment of osteoporosis prior to the first fracture a priority for public health." The "call to action" is based on a report released previously by the International Osteoporosis Foundation—a kind of global umbrella for national groups. On the final pages of that report, a few lines of fine print acknowledged the sponsors, who provided "unrestricted educational grants to enable us to produce the report." There are eight sponsors and they are all global pharmaceutical companies. Lilly is the "Gold Sponsor."

Intuitively early diagnosis and prevention make perfect sense, but the debate within the medical literature about osteoporosis is far more complicated than these simple messages reveal. While it is not at all clear from the publicity material and the media stories, there is a genuine scientific controversy about the role of bone mineral density scanning in predicting a person's future risk of fracture. There are also complex cost-effectiveness arguments about the value of extending subsidised tests and treatments to the millions of relatively healthy women who have not had a fracture.

STEVEN GOVERN/AP

Camilla Parker Bowles: call to action

One of the other high profile people at the Lilly-supported Roundtable of International Women Leaders was the former governor of Texas, Ann Richards. Just days after that Lisbon meeting Ms Richards appeared on CNN's Larry King show, talking about the star-studded roundtable on osteoporosis and strongly endorsing the value of a good diet and plenty of exercise. She also revealed she was taking a medication. According to the transcript, she told Larry it was "Evista. It works for me." Her assistant later confirmed that Ann Richards worked for Lilly from time to time.

Back in New Jersey, Amy Doner Schachtel is explaining the changing role of celebrities in raising awareness about diseases. "Companies originally wanted the biggest names, the biggest stars. Now it is finding the celebrity with the right fit—someone who has genuine connections, through suffering the condition themselves or having a family member or friend with the condition," she said.

The woman who organised the Lisbon meeting, where Camilla Parker Bowles made her first big public speech, was Mary Anderson, from the International Osteoporosis Foundation. She confirmed that Lilly paid the airfares and accommodation of Ann Richards and some of the other high profile guests, but that Mrs Parker Bowles paid her own way. Asked about the influence of drug company sponsorship in raising awareness about osteoporosis, she said that individual brands were most certainly not promoted. "The International Osteoporosis Foundation doesn't want to have anything to do with product endorsement. The more proven medications for people the better. The more the merrier."

Ray Moynihan *Australian Financial Review*
ray_128@hotmail.com

P+ *Website extra: Psychology for blokes. A review of a television programme on how a sports psychologist is helping the England team prepare for the World Cup is available on bmj.com*

PERSONAL VIEW

Football yes, surgery no

The main purpose of the football premiership is to provide entertainment. Competition is a source of excitement in sport, and league tables are essential tools to measure success. The prime target of cardiothoracic surgery is to restore health, often in life threatening circumstances. The process requires the application of highly technical and skilled surgery, anaesthesia, and intensive care by numerous professionals, to achieve a favourable outcome for the patient.

At first sight it may appear useful to introduce an element of competition as an incentive to improve performance. However, publishing league tables that claim to provide evidence of standards in health care can deceive the public, make patients anxious, and be scornful and demotivating for healthcare professionals.

Inferior premier league football clubs get relegated and replaced by new contenders every season. Sampling errors are virtually impossible and confidence intervals do not feature. No stratification of results is required and the ranking is the intrinsic reason for their existence.

However, surgeons placed at the bottom of a cardiothoracic surgical league table are not easily replaced if their performance is considered below par. By definition, half of all the cardiac surgeons in the United Kingdom will be of below average performance. The lowest ranking professionals may not receive a valid assessment of their patient caseload. The entire aspect of "teamwork" in NHS units is ignored and team shortcomings reflected in poor outcomes will be blamed on the individual cardiac surgeon. Although we frequently see premiership managers sacked unceremoniously for poor results, what fate will befall the surgeon?

The competitive ranking of cardiac surgeons' performance in daily newspaper supplements will hardly benefit patients. Instead, patients are likely to feel anxious as they perceive disparities between NHS regions. Furthermore, league tables, as recently published by Dr Foster (bmj.com/cgi/content/full/324/7336/552), adversely modify surgeons' attitudes. Clinical decision making will start to reflect surgeons' concerns over their position in the "premiership" tables. It is known that the highest risk patients have the most to gain from successful cardiac surgery—in the new era, will these patients get that chance?

A recent survey of all cardiac surgical consultants indicated that, if league tables were to be introduced, more than 90% would modify their practice to avoid high risk patients. This may reduce revascularisation rates at a time when the government is committed to increasing them and would lead to the deaths of more patients through lack of surgery rather than to the detection of any individual "high mortality" surgeon.

League tables could also undermine the future provision of surgical care. Already some consultant supervisors are reluctant to provide adequate training to the next generation. Because of their concern over the influence an adverse result may have on their league table position, some consultants are handling cases where there should be consultant supervised training. With good supervision, there should be no risk to the patient, but league tables have changed the consultant mindset. As a result, future consultant cardiac surgeons are likely to be considerably less experienced at the time of appointment than their predecessors.

> League tables will inevitably result in additional premature deaths

The legendary football manager Bill Shankly once said: "Some people think football is a matter of life and death. I assure you, it's much more serious than that." Likewise, surgical performance league tables, therefore, are not merely a measure of life and death—it's more serious than that. League tables will inevitably *result* in additional premature deaths, as hazardous operations will be denied or standard operations will be performed by less competent future consultant surgeons.

Despite increasing volumes and the worsening general health of the cardiac surgical patient population, overall mortality rates have steadily decreased in the 36 NHS trusts in the United Kingdom providing cardiac surgery. Such progress is a reflection of multifaceted improvements—in, for example, referral principles, medical therapeutics, anaesthetics, and postoperative intensive care.

When assessing the efficiency of healthcare systems, complex performance indicators have superseded isolated mortality rates. The outcome of such sophisticated "systems" assessments differs markedly from convenient monocausal approaches. Control charts, for example, allow detailed analysis of adequacy of providers without comparative ranking.

We need refined tools to assess and display consultants' and their units' performances. It is in everyone's interest that fair and transparent outcome data is available to the public. Medical professional societies, legislative representatives, and the media must make concerted efforts if these are to succeed.

Christopher Wigfield *specialist registrar in cardiothoracic surgery*
Stephen C Clark *consultant cardiothoracic surgeon, Freeman Hospital, Newcastle upon Tyne*

SOUNDINGS

Mentioning the war

Like service doctors thrown together anywhere we chatted and joked and discovered mutual acquaintances. Routines were undemanding, almost token. Morning newspapers were enjoyed at leisure and lunch often stretched towards afternoon tea.

The hospital was all but empty. We were its temporary staff, reservists on UK duties while our regular colleagues—as they put it—went south. We were briefed. We were ready in our fashion. We waited.

For me it was opportune; there was a novel to revise and this was blameless time for it. Others were less content. A couple of London orthopods, perhaps more accustomed to busily knocking hips into duchesses in Harley Street, coped rather badly with having nothing to do. I think they once actually tossed a coin for the privilege of dealing with a sailor's ingrown toenail. Most settled eventually into the routine of idle readiness.

On Sunday in the little Georgian chapel the closing hymn was the usual one: expected and traditional but now something more. Under dusty ensigns and memorial plaques, in a naval hospital that still bore the scars of Luftwaffe bombing, we sang together "Eternal father, strong to save . . ."

Each weekday at six o'clock the medical mess television lounge was full and silent. A civil servant, suddenly a national figure, read bulletins solemn and terse. We heard of ships we knew, with doctors we knew serving in them, being attacked and even sunk. Then we went for a drink.

Each day the empty wards waited. There were plans: complex schemes involving hospital ships, air links, airborne intensive care teams, RAF stations not far away, and then hospitals like ours, and us, with hundreds of beds at the ready.

Ours was the worst case scenario: mass casualties from a troopship or a carrier ravaged by missiles and fire. Days passed. The ships hit were the smaller ones, with good drills and training minimising losses. But each evening we gathered, prepared to hear the worst.

Twenty years on it is clear that different luck, a few more Exocets, even a millimetric adjustment to the fusing of simple bombs, could have made a huge difference. But in 1982 a small miracle of organisation in a former meat processing plant, backed up by the hospital ships and air links, coped astonishingly with the wounded from both sides. We simply watched a far-off war on television each evening, and waited. Nobody came.

Colin Douglas *doctor and novelist, Edinburgh*